Please fill out this form. If you are uncomfortable answering any questions, leave them blank. You can discuss them with your doctor or nurse.

Print Name ______________________ **Date of Birth** ____________ **Today's Date** ____________

Preferred Pharmacy and Address____

- What is the reason for your visit today? ____

____

- List any changes to your medical, surgical, or family history: ____

____ • Primary Care Physician: ____________________

- First day of your last menstrual period? ____________ • Present method of **birth control**: ____________________

REVIEW OF SYSTEMS (PLEASE INDICATE IF ANY OF THE FOLLOWING SYMPTOMS APPLY TO YOU NOW.)			
CONSTITUTIONAL	**PHYSICIAN NOTES**	**GENITOURINARY**	**PHYSICIAN NOTES**
☐ WEIGHT LOSS		☐ BLOOD IN URINE	
☐ WEIGHT GAIN		☐ PAIN WITH URINATION	
☐ FEVER		☐ STRONG URGENCY TO URINATE	
☐ FATIGUE		☐ FREQUENT URINATION	
☐ CHANGES IN HEIGHT		☐ INCOMPLETE EMPTYING	
EYES		☐ INVOLUNTARY/UNINTENDED URINE LOSS	
☐ DOUBLE VISION		☐ PAINFUL INTERCOURSE	
☐ SPOTS BEFORE EYES		☐ INFERTILITY	
☐ VISION CHANGES		☐ DES EXPOSURE	
☐ GLASSES/CONTACTS		☐ ABNORMAL VAGINAL DISCHARGE	
EAR, NOSE, AND THROAT		**SKIN**	
☐ EARACHES		☐ MOLES	
☐ RINGING IN EARS		☐ SORES	
☐ HEARING PROBLEMS		☐ DRY SKIN	
☐ SINUS PROBLEMS		☐ RASH	
☐ SORE THROAT		**BREASTS**	
☐ MOUTH SORES		☐ PAIN IN BREAST	
☐ DENTAL PROBLEMS		☐ NIPPLE DISCHARGE	
CARDIOVASCULAR		☐ LUMPS	
☐ PAINFUL BREATHING		**NEUROLOGIC**	
☐ CHEST PAIN OR PRESSURE		☐ DIZZINESS	
☐ DIFFICULTY BREATHING		☐ FAINTING	
☐ SWELLING OF LEGS		☐ NUMBNESS	
☐ RAPID OR IRREGULAR HEARTBEAT		☐ TROUBLE WALKING	
RESPIRATORY		☐ SEVERE MEMORY PROBLEMS	
☐ WHEEZING		☐ FREQUENT OR SEVERE HEADACHES	
☐ SPITTING UP BLOOD		**PSYCHIATRIC**	
☐ SHORTNESS OF BREATH		☐ DEPRESSION OR FREQUENT CRYING	
☐ CHRONIC COUGH		☐ SEVERE ANXIETY	
GASTROINTESTINAL		**ENDOCRINE**	
☐ FREQUENT DIARRHEA		☐ HAIR LOSS	
☐ BLOODY STOOL		☐ HEAT OR COLD INTOLERANCE	
☐ NAUSEA/VOMITING/INDIGESTION		☐ ABNORMAL THIRST	
☐ CONSTIPATION		☐ HOT FLASHES	
☐ INVOLUNTARY LOSS OF GAS/STOOL		**HEMATOLOGIC/LYMPHATIC**	
MUSCULOSKELETAL		☐ FREQUENT BRUISES	
☐ MUSCLE WEAKNESS		☐ CUTS DO NOT STOP BLEEDING	
☐ MUSCLE OR JOINT PAIN		☐ ENLARGED LYMPH NODES OR GLANDS	